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A BRIEF STUDY OF MILITARY MEDICAL PROCEDURES AT ANNUAL TRAINING,
SOME PROBLEM AREAS THAT HAVE ARISEN,
AND RECOMMENDATIONS TO ADDRESS THESE PROBLEMS,
FROM THE EXPERIENCE OF A BATTALION CHAPLAIN

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BACKGROUND

During the period of Annual Training (AT) any battalion sized unit will experience medical emergencies; some of these will likely be serious and produce stress to the individual, his dependents and the unit. Sudden illness and/or major accidents are never expected and are often not prepared for.

Most serious incidents occur while the unit is in the field, often towards the end of the field training period when stress is the highest and fatigue the greatest. Commanders, staff and NCOs, already overloaded with training requirements, have little time to devote to individual emergencies, however serious. Decisions must be made immediately with inadequate time, personnel, information, communication and equipment.

To avoid major errors, all personnel involved in handling medical emergencies should be thoroughly familiar with all procedures, resources, ordinary and extraordinary evacuation procedures, the identity and location of higher medical resource units, what equipment is actually available, who makes appropriate decisions, and how information is disseminated.

It has been the experience of this author, in his assignment as a battalion chaplain, that often information is inadequate and incomplete, that the Bn medical section, subject as it is to change in personnel, is not always aware of potential problems, and that the SOPs of the various medical echelons are often sufficiently different as to cause gaps in medical coverage. (cf case studies 1 & 2). The chaplain, as the one staff officer sufficiently free from fixed duties to give personal attention to individual problems, is often called on to assist in these emergencies, to spot problem areas, and assist in working out immediate solutions.

This paper will explore the designated medical procedures to be followed at AT; this information has been gained from consultation with medical people at various times. Then the paper will articulate problem areas from the perspective of a Bn chaplain, as experienced at many ATs. Finally this paper will make recommendations for steps to anticipate and avoid problems at future AT periods.

DESIGNATED EVACUATION PROCEDURES BATTALION RESOURCES AND RESPONSIBILITIES

The HHB 1/86 FA, has a medical section authorized a section chief, 9 aidmen, and a physician's assistant (PA); there is no physician as part of the unit. There are one or more vehicles available as ambulances, depending on total number of vehicles on hand for the Bn for that AT.

Each day an aidman is dispatched to the firing batteries and the observation post; the Bn aid station is located in the Bn

trains, near the ALOC, with the ability to be in radio contact with the aidmen. The aidman treats any injuries within his abilities on the scene and the individual continues on duty.

When an injury is beyond the ability of the aidman, the individual is to be transported to the Bn aid station in the vehicle provided by the medical section or the supported battery. The Bn PA judges if the case is within his ability and handles those he can treat; individuals are then returned to duty from the aid station.

MEDICAL COMPANY SUPPORT

If the case requires the attendance of a physician, it is referred to the supporting medical unit. The VtARNG has Co D, Medics as a resource during IDT; at AT this unit is sometimes assigned in support, providing a receiving station, dispensary, and field hospital. At other times another medical unit of the 50th Armored Division is designated as support.

In combat, the higher medical unit evacuates casualties from the lower unit. At AT the medical company seldom has the personnel or vehicles to perform this function, so it falls to the Bn medical section both to evacuate and to recover Bn casualties. This often strains the Bn medical section's resources.

SEVERE CASUALTIES

If a case requires more than a night or two of hospitalization, the individual is transported to the Wilcox Clinic on post at Ft. Drum. At AT a reserve hospital unit is designated to run that part of this facility devoted to the reserve units; the permanent medical party treats only the Ft. Drum personnel. In theory, the Post Hospital is always fully staffed and ready to treat reservists.

Transportation to and from the Wilcox clinic is supposed to be the responsibility of the clinic as the higher echelon. Most often it falls to the medical company, or even the soldier's parent unit to provide the transportation.

If the clinic judges the case too severe for its resources, or if the casualty is likely to require extended hospitalization, he/she is transferred rapidly, usually to one of the two civilian hospitals in Watertown, N.Y. He/she is assigned a civilian physician for the stay at the hospital, and one of the post physicians monitors the condition for the military. But none of the Vermont doctors is directly involved at this point.

MEDIVAC

If an injury happening in the field is unusually severe, the aidman may call for an air evacuation directly from the Wilcox Clinic; the patient is flown directly from the clinic, bypassing the Bn and medical company echelons. Really severe cases are flown immediately to the civilian hospital.

EXTENDED HOSPITALIZATION

If extended hospitalization is needed the individual is evacuated to the nearest full military medical facility when his/her condition permits. It is military policy to leave the individual in a civilian hospital no longer than is absolutely necessary. Since the Wilcox Clinic is not equipped for extended stays, the individual is entered into the army medical evacuation system; for Vermonters this usually means hospitalization at Ft. Devins, Mass.

DEPENDENTS OF RESERVISTS

The army does not encourage dependents of reservists to come to Watertown during the individual's stay in the civilian hospital; Ft. Drum has no provisions for housing of reservists' dependents. The civilian physicians, however, often encourage the dependents to come, to benefit of the patient's morale. This conflict of advise often causes real problems, which are aggravated if the dependent follows the patient to the military medical facility. Dependents of reservists are not recognized under these circumstances.

RETURN TO DUTY

If the soldier can return to duty before AT ends, he is returned to the Wilcox Clinic first, since the civilian hospital deals only with the Clinic; the Clinic transports the patient back to the Post, where his/her condition is evaluated and the decision made to hold or release him/her.

Standard procedures of release from a higher to a lower echelon call for the patient to be returned to the Medical Company, which, in turn, releases him/her to the parent unit, for return to duty under whatever conditions the physicians have prescribed. Often at AT the individual is returned directly to his unit with no interaction with the Medical Company or the 86th Brigade.

SOME PROBLEM AREAS

SHORTAGE OF RESOURCES, PERSONNEL AND EQUIPMENT

At AT the medical section often must perform functions not assigned to it in the TOE. For example, the medical company in support is often unable to transport to and from its location, so the task falls to the Bn aid station to do this. The battalion, however, is often hard pressed to supply authorized equipment to its many sections, and cannot supply additional items (e.g. while it is important for each aidman to be in radio contact with the Bn aid station, there are not enough radios to issue one to the aidmen.)

The number, training and experience of people for the medical section varies from year to year. At times there is a large turnover of personnel in the section in a single year; several of the assigned aidmen may be at basic training, and others who are present may be new to the job. When these conditions exist, there is greater potential for serious errors, especially if they are assigned several jobs with which they are not fully familiar.

PROCEDURES IN PRACTICE DIFFERING FROM PROCEDURES IN THEORY

Often actual procedures differ from procedures learned in basic training. This difference arises from actual need at the time of a situation, but sometimes personnel are not aware of the discrepancy. For example, established procedures provide for higher echelons to transport casualties from lower echelons. The TOE reflects this doctrine by authorizing only that equipment necessary to transport to the Bn aid station; the TOE presupposes that the supporting medical company in combat will provide the transportation. At most ATs, however, the supporting medical company cannot perform this function, so the Bn must supply its own transportation to the medical company site, in spite of its own shortages.

INFORMATION ON THE LOCATION OF UNITS

All units at AT assume a tactical posture in the field, including the medical company; both the supported unit and the medical unit are constantly moving tactically. It is essential, therefore, that the Bn aid section know completely the present and future location of its own units and of the medical company.

All too often this information is inaccurate, outdated, or completely missing. Occasionally aidmen cannot find the firing battery they are supporting, or they do not know the location of the medical company for many hours after a tactical move. This can cause lengthy delays in transportation and risk of further injury.

INFORMATION ON THE STATUS OF MEDICAL SUPPORT

Battalion and brigade medical personnel assume that the medical support from the medical company and the Wilcox Clinic will meet designated standards at every AT. This is not a wise assumption because medical units themselves are in a training posture and have differing quality of performance from one year to the next.

In addition, the schedule of the unit supporting the Wilcox Clinic is often different from that of the Vermont units, or even from its own relieving unit. Case study # 1, enclosed, demonstrated what can happen when one medical unit leaves its AT post before the following unit is operational. It is the experience of this chaplain that the Vermont medical personnel do not obtain information on the reserve unit staffing the Clinic (its size, its capabilities, its training schedule and its presence at AT) before arrival on Post.

Information on the medical company in support of the Bn aidmen

is also essential, but often lacking. There is frequent interaction between the Bn medical section and Company D Medics during IDT; usually Company D is at AT with the 86th Brigade. In case study #2 some assumed that Company D has the mission to be the support medical company for the Vermont units at that AT. That year a unit from another state was the support unit. If the Bn aidmen are not aware of this they may seek medical support from the medical company that does not have that mission. Time is lost in learning which unit has that mission and there are further delays in establishing working contacts with the proper unit.

Also, the supporting medical unit often has periods of limited availability. Periodically these units undergo an ARTEP. This period of testing, stress and movement often reduces the actual availability of the company to its supported units.

The Bn medical section can compensate for lacks at any given time by calling on the brigade surgeon or the other medical company at AT, if conditions warrant such reinforcement, but they must have timely information on the status of its assigned medical support.

LACK OF UNDERSTANDING OF MILITARY MEDICAL PROCEDURES

National Guardsmen are civilians temporarily in the military environment, and are apt to expect the military will follow the medical procedures of the civilian sector. Such assumptions led to the difficulties detailed in the enclosed case studies. Because no one begins AT with the expectation of being hospitalized, few take the time to become familiar with military medical procedures.

This difference in expectations is worsened when a soldier is in the Watertown hospital, where procedures and philosophy are sufficiently different from those of the military as to create problems. For example, the military discourages the dependents of reservists from coming to the hospital, whereas the hospital encourages visits. Thus the individual and his family receives different advice during the same illness.

MANY PHYSICIANS INVOLVED IN THE CASE

If a soldier is evacuated to the civilian hospital by way of the medical company and the Clinic, he/she has been in the care of at least two military physicians and one civilian physician; often he/she has his/her own physician at home. Although the brigade surgeon is usually not directly involved, there is the need for a Vermont medical officer to monitor the case; this task often falls to the brigade surgeon.

While the patient is in the civilian hospital, he/she is under the care of a civilian physician. A Ft. Drum physician monitors the case to determine when to return the individual to military control; relationships and communication between these physicians is sometimes not the best. In rapid succession the patient may be transferred to the Clinic, to a Watertown hospi-

tal, to Ft. Devins, then to home station when his/her own physician becomes involved. This rapid change of physicians was a major problem in case study # 1, and is a potential area of difficulties in the future.

INFORMATION ON THE PATIENT'S CONDITION

The above situation often creates confusion about the patient's condition, diagnosis and prognosis. The different physicians, operating under differing procedures, sometimes give conflicting information on what will happen next. This is most disturbing to the patient and his/her dependents.

In addition, members of the parent unit, because of their personal concern, often seek information from whatever source they can: sometimes from the civilian channels, sometimes from the military, sometimes from hospital visitors, sometimes indirectly from the patient. Much of this information is inaccurate and distorted. But these reports tend to reach dependents before official military information does. By the time this official information works its way through channels unfamiliar to the patient and his/her dependents, its credibility has been compromised.

STRAINED FINANCIAL RESOURCES

Often soldiers, especially of lower rank, have few financial resources, and come to AT with no reserves, not even pocket money until AT payday. A medical emergency places unexpected demands on a family, especially if the family elects to come to the hospital.

If he/she is transferred to a military facility some distance from home there is the added cost of visiting, since the military cannot assume responsibility to house or transport dependents of reservists. If the individual has a lengthy convalescence he/she will receive military pay, but this is often delayed, requiring the family to live from its resources for a time.

If individuals are not financially prepared for these financial realities, financial stress is added to all the other problems.

ADDRESSING THE NEEDS

INFORMATION

The most basic need is accurate, timely information that is available to, and understood by, all those who are involved in medical support. Basic information must be available to all members of the unit before it is needed, since the push of an emergency makes it difficult to secure facts.

The individual soldier must know what will happen in a medical emergency, from its inception to its ultimate resolution. He must know the evacuation procedures to expect, the procedures of hospitalization at AT, what happens if an illness extends beyond

AT, and how to obtain needed medical, personal and financial support.

Dependents need to know how to obtain accurate information on the patient's current and future status. They must know the factors involved if they choose to visit Watertown, to decide if this is feasible.

Units and their members must know how information will flow. Soldiers must be willing to observe these procedures and not attempt to circumvent them.

The Bn medical section must know the identity, schedule and capability of supporting medical units and personnel. It must assess the physical assets available to the section at AT and make provisions accordingly. It should get both general and specific information to the sections before movement from home station.

At AT the Bn medical section must know the location of its support resources at all time. It must be aware when and where supplies will be available. It must know if there will be periods of reduced medical support at AT.

ASSIGNMENT OF SUPPORT ROLES

At AT there are support people available for medical emergencies, including: the chaplain, the S-1, the brigade surgeon, and the S-2. Battalion medical personnel should meet with these people to define availability and roles when emergencies do arise. All of these should agree to their respective roles and provide the agreed to services.

COMMUNICATION

Above all, timely, accurate communication between everyone involved in medical coverage and handling of emergencies is essential before, during, and after an emergency. All involved must know which person has the correct information needed and avoid other sources.

RECOMMENDATIONS

BEFORE THE START OF THE ANNUAL TRAINING PERIOD

1. A brief fact sheet of medical procedures should be made available to each member of the unit, and a copy furnished to the dependents to be left in an accessible place at home.
2. It is the responsibility of the PA of the medical section to learn which medical company will be in support of the Bn at AT, and the initial location of that unit.
3. The Brigade Surgeon should coordinate with the Medical Company which will be in support of the 86th brigade to insure that expectations and procedures are understood. He should also find

the status of coverage of the Wilcox Clinic during that period and evaluate the quality of medical care. If he anticipates times of gaps in coverage he can arrange reinforcement beforehand.

4. Bn medical people must know the schedule of operation of Post facilities; there have been times when the section planned to draw supplies on arrival at Post, only to discover that the facility was closed because of a holiday.

DURING NORMAL ANNUAL TRAINING OPERATIONS

1. Bn aidmen should know radio procedures and find the location of the nearest radio when they reach an assigned unit; since the Bn aid station is located near the ALOC they can be in constant contact with the aid station.

2. The PA should constantly coordinate with the S-1 and the chaplain with information on patients that have been evacuated from the unit; these should discuss the status of the patient at least daily.

3. The S-2 is in the best position to learn the location of medical support units in tactical situations; the PA must constantly consult him for updated information. Often the chaplain also knows this information from the brigade chaplains' support chain.

4. Immediately on arrival at AT the PA must determine who will actually take responsibility for transporting of patients to the medical company or to the Wilcox Clinic, and how the process of returning to the parent unit will take place. Aidmen must know what paperwork must be present before evacuating or recovering a patient (cf case study #2).

5. When a patient is being transported to a higher echelon he/she should be briefed on what to expect; perhaps a brief written outline could be made available describing the current SOP. Before the patient is left at the facility the Bn aidman should determine when and where the next contact with the Bn will be made.

IN CASE OF A MEDICAL EMERGENCY

1. Copies of the Medevac procedure should be readily available to all sections of the unit, especially the TOC and aid station.

2. Immediately after an emergency evacuation has been called for, the aidman should contact the Bn aid station with the details as accurately as possible. These facts should be relayed to the S-1 and the chaplain immediately.

3. The unit commander must designate the person who will see to the patient's immediate personal needs; this will often be the chaplain and/or the unit AST, but this responsibility must be assigned and not assumed. It is usually a comfort to the patient

to have personal effects brought to the hospital as soon as possible.

4. The commander's designee assumes responsibility to notify next of kin as soon as possible. Since news will likely be relayed to the individual's home in short order, it is essential that accurate information be relayed first. If possible the patient should speak to home directly. In all cases the dependents should be asked to consult the fact sheet given them before AT began.

5. Only the commander or the S-1 should be authorized to give information about the patient's condition to members of the unit; these individuals should keep well informed, but all other members of the unit must be instructed not to contact the hospital or the Clinic.

6. The Brigade Surgeon should be notified when an individual has been admitted to the Wilcox Clinic or a Watertown Hospital; it would then become his task to coordinate information about the status of the patient and succeeding steps to the patient and the dependents.

7. The chaplain will likely be consistently available to the patient for spiritual and personal needs; he may have timely advice about dependents coming to visit, and assisting if they so choose. With the S-1 he will support the patient and the dependents, but make dependents aware that visitors assume full responsibility for their stay at Watertown.

8. Should the individual be in the Watertown Hospital or the Wilcox Clinic when the unit moves to home station at the end of the AT period, the S-1, with assistance of the chaplain, will arrange for any personal support he/she needs while away from the unit. But they will take care to provide accurate information to the patient of the military medical system when it is determined that the patient will spend some time in a military hospital.

CASE STUDY #1

In May 1982 1/86 FA moved to Fr. Drum for AT. On Saturday evening, the seventh night in the field, SSg A. suffered symptoms of a heart attack and was air evacuated to a Watertown hospital after a brief evaluation at the Wilcox Clinic; the evidence was unclear whether he had suffered a heart attack. Maj. M, the Bn chaplain, and SFC L, his units' AST accompanied A to the hospital, brought his personal effects and notified his wife, W, of the illness; they advised she not come to Watertown.

A was admitted to the CCU for observation, his condition listed as guarded (SOP for such illnesses), in the care of a civilian physician. Neither A nor W knew the military medical procedures; L and M knew of them only from other experiences of hospitalization of unit members at past ATs. W decided to come to the hospital partly because the attending civilian physician advised it; she had very little money. Capt B, the S-1 arranged for on post housing for W, and M took responsibility for transportation.

On Sunday A's unit moved to Post from the field. His many friends besieged the Clinic and the hospital for information on his condition; his diagnosis and prognosis was quite uncertain because it appeared he had not suffered a heart attack at all. But several physicians and several nurses were giving differing readings to A and W who, in turn, relayed these inaccurate reports to friends in the unit. Soon many wild reports were circulating.

Almost immediately A began to press the question where he would be sent next. M found out from Capt O, administrator of the Wilcox Clinic, that military policy dictated that A be returned to military control ASAP and be sent to the most suitable military hospital as soon as his condition allowed. A insisted he be sent to the VA hospital near his home, but O would not allow this because of the 5 hour ambulance ride; he had determined that that air evacuation was not possible. A's friends began to press O to change his mind, but O made arrangements for A to be air evacuated from Griffiths AFB to Ft. Devins, Mass., on Tuesday.

But, when the civilian physician learned this would require a two hour ambulance ride to the site of air evacuation, she refused to release A on time for the flight. Since the next flight was a week away, O had no choice but to allow A to be transferred to a private room in that hospital. But he was under pressure to return A to a military facility.

On Wednesday the hospital released A to the military; it was becoming more evident that A had not suffered a heart attack, but it was not yet certain. O assigned A to the Wilcox Clinic in care of the reserve unit in charge of the reserve medical care for that AT cycle. B and M were trying to assist A, W, and their friends in the unit, but no SOP existed for guidance, consistent,

accurate information was hard to come by. There was no single medical voice to speak about A's diagnosis or prognosis. A and his friends were continually pressing their demands that he be assigned to the VA hospital.

A arrived at the Wincox Clinic on Wednesday evening. 1/86 FA was preparing to return to home station on Friday. The reserve medical unit at the Clinic had already begun its move to home station, but no element of the relieving medical unit had arrived to take his case in charge. Advance element of the next major unit to come to Ft. Drum were due to arrive; since they needed all available billeting W would lose on post housing, and she could not afford a motel room. A experienced a severe lack of care, medical or personal, because of the lack of personnel at the Clinic; no one was willing or able to address this problem. (This lack became the subject of an IG action). M managed to convince W to return home with the unit on Friday. B remained on post to follow up on A, who remained there until Monday, when he was moved to the VA Hospital that he had originally wanted. It was eventually determined his symptoms had few physical origins.

This experience demonstrated several areas of serious deficiency:

- 1) Individuals of the VtARNG are not aware of military procedures when hospitalization extending beyond AT is needed; Guardsmen have come to expect a more personal, individual atmosphere that a "hometown" unit provides than the active military can provide.

- 2) Dependents are not aware of the problems their presence can present in an unfamiliar military environment; they lack the experience, information, or resources necessary for an extended stay in Watertown or on a military post.

- 3) There is no single source of reliable military information for the patient from a reserve unit.

- 4) There is no single, reliable source of information to dependents and friends on the patient's medical condition.

- 5) Civilian and military physicians do not always communicate and interact effectively.

- 6) The comings and goings of the reserve medical units at the Wilcox Clinic is not carefully monitored, leaving the potential of dangerous gaps in care.

- 7) If a patient must remain at AT after finish of the cycle, virtually all sources of personal support are removed.

- 8) Caring friends and relatives are often more of a hindrance than a help in such emergency situations.

- 9) No known SOP exists, (for the guidance of medical personnel, patients, dependents, chaplains etc.) for medical emergency in a training posture; some elements of the tactical SOP for medical care do not, and cannot apply at Ft. Drum, in a training situation.

CASE STUDY #2

In June 1984, 1/86 FA was at Ft. Drum for AT. The Bn medical section was shorthanded; those present at AT were relatively new to the job. Co D, Medics, often the support medical unit for the 86th brigade was scheduled for ARTEP, so Company A, from another state, received that mission.

On Friday of the tactical period SSg B strained his back; because he had a history of back problems he was med-evaced to the Wilcox clinic for evaluation. Maj M, the Bn chaplain, accompanied him onto the Post.

The medical unit at the Clinic determined that B's condition was not serious, that he would be held for observation overnight, then released for duty at noon the next day.

When M returned at noon to inquire about B's condition he learned B had been discharged; but there was no record of his condition or where he had been sent. M visited Company D and found no trace of B. He found Company A and still there was no record of A's having been there. By 5:00 P.M. M arrived at B's location in the field to find a very upset 1st sgt. with a sick soldier on his hands. B had been returned to his unit with no instructions as to his condition, treatment, or restrictions for duty. He was still in great pain, was unable to function in any way, yet had no authorization for absence from his unit. M arranged for the Bn medical section to authorize his return to Post, with the approval of his commander, then undertook to find out what had happened.

The story that unfolded indicated some areas of concern in this area. The Wilcox Clinic had identified Company A as the next lower echelon of medical care; at this AT, unlike many other years, the Clinic assumed transportation responsibilities, and had taken A from the Post to the location of Company A. B, however, was not aware that he was expected to sign into Company A for the next step of his evaluation; the driver who brought him there simply left him at the site. The registrar of Company A had no record of B or his sickness, since he had been transported directly to the Clinic, with no coordination with Company A before, during, or after the evacuation. Evidently the Wilcox Clinic assumed that the physicians of Company A were responsible to make determination of what duties B could assume.

At 2:00 P.M. an aidman of the 1/86 FA arrived at Co. A seeking B. This aidman was also unaware that B should have registered with Company A for evaluation, so he transported B to his battery in the field; there were no instructions for light duty. After B's commander authorized light duty on post, M made arrangements with Company D for a physician to visit the post and make the determination that was lacking.

This experience indicated some potential problem areas:

1) Members of the VtARNG are not aware of the normal medical procedures followed in an emergency at Annual Training.

2) No SOP is evident to guide medical personnel, chaplains, or soldiers on procedures to be followed in a training situation; tactical SOP's, suitable for a combat environment, don't always apply in a training situation at Ft. Drum.

3) No single member of 1/86 FA is tasked to find relevant information about medical coverage for a particular AT period (eg. which medical company has been assigned coverage, its location each day, who must assume actual responsibility for transportation at various echelons).